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	085043	A. BUILDING _____ B. WING _____	C 09/03/2010

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F 000	INITIAL COMMENTS 10/27/10 Revised report without IDR. Text changes to F 221. An unannounced annual survey and complaint visit was conducted at this facility from August 18, 2010 through September 3, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was eighty-six (86) residents. The survey sample totaled thirty-four (34) residents.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: EXECUTIVE DIRECTOR | (X6) DATE: REVISED 10/28/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and	F 156	**F 156** 1 & 2. Resident's Rights in its entirety was reviewed at the Resident Council Meeting held on September 15, 2010 Resident # R82 was present and participated in the meeting. 3. The Resident's Rights will be reviewed annually in its entirety. This review will be included as an agenda item for one Resident Council meeting annually. The schedule for the Resident's Rights review will be posted in advance. 4. A report of the Resident's Rights review and discussion will be presented at the first Quality Assurance Meeting following the Resident Council meeting for review and discussion	**9/15/10** **9/24/10**

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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on document review, and resident and staff interviews, the facility failed to periodically review resident's rights during residents' stay at the facility. Findings include: Review of resident council meeting minutes lacked evidence that resident rights were	F 156		

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F 156	Continued From page 3 periodically reviewed with the residents. Review of the facility admission packet revealed that resident's rights were included in the packet when residents were admitted to the facility. Interview with R82 on 8/23/10 revealed that the facility did not review resident's rights with the residents during their resident council meetings or any other time during their stay at the facility. Interview with E5 (Admin & Religious Life Director) on 8/30/10 revealed that the facility reviewed the residents rights with them upon admission and if a question was to arise but that these discussions were not documented.	F 156		
F 221 SS=G	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that two residents (R15, R5) out of 34 sampled were free from any physical restraints. The facility failed to ensure that R15 was free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. R15 had a history of multiple falls and had attached a lap buddy (without medical indications) on her wheelchair when out of bed which she could not remove. The facility failed to develop a systematic and gradual process toward reducing	F 221		

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F 221	Continued From page 4 the use of the lap buddy. The facility failed to use alternatives, such as a less restrictive device for the least amount of time per day. The facility lacked documented evidence that the lap buddy was released every 2 hours for 10 minutes as per the care plan. The record indicated that R15 was resistant to the use of the lap buddy and indicated that R15 made attempts to slide under the lap buddy on 3 occasions. The facility's response was to immediately administer Ativan gel to her wrist. The facility failed to recognize that when seated in the wheelchair with a lap buddy, the lap buddy became a stressor to R15 and contributed to her increased agitation/anxiety, depression, emotional outbursts, physical and verbal abusiveness to staff. Additionally, during lunch time observation, R5's lap buddy was not removed from her wheelchair and the wheelchair did not fit under the table. At this time the lap buddy restrained R5 from reaching her food on the table. Findings include: The facility's "Restraint Policy" and the "Restraint Reduction Policy " were reviewed. 1. R15 was admitted to the facility with diagnoses of Hypothyroidism, Hypocalcemia, Senile Dementia, dementia with psychosis, and Essential Hypertension. According to R15's annual Minimum Data Set (MDS) assessment dated 8/26/09, her cognitive skills for daily decision-making were "modified independence-some difficulty in new situations only " . R15 was independent with ambulation, bed mobility and transfer, and needed limited assistance of one person with her other ADLs (activities of daily living) such as toilet use, personal hygiene and physical help with bathing. She had no indicators of depression, anxiety and	F 221	1. No action can be taken for R15, as the resident has expired. The nursing staff caring for R5 was in serviced on restraint release. R5 was evaluated for restraint use and remains appropriate for use. (See attached) 2. Every resident with a restraint has been evaluated for a restraint reduction at the SWIFT (Skin, Weights, Infections and Falls Team) meeting using the Restraint Reduction form (See attached). All residents with restraints will have signed consents that include risks and benefits in the medical record. 3. The restraint policy has been reviewed and revised to now include a new Pre-Restraint Evaluation form (See attached) and will be completed prior to obtaining a restraint order. All residents with restraints will be reviewed monthly at the SWIFT meeting by the interdisciplinary team. A new restraint consent form (See attached) has been implemented. CNA flow sheets (See attached) have been revised to include the documentation of the removal of the resident's restraint. A resident seating chart for the satellite dining room has been created and implemented to facilitate monitoring and assistance of all residents. Nursing staff have been assigned specific tables to maintain continuity of care. In-services will be provided to nursing staff by 10/15/10.	

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F 221	Continued From page 5 sad mood but exhibited "verbally abusive (to staff) behavioral symptoms 1-3 days in the last 7 days " which was easily altered, and " socially inappropriate/disruptive behavioral symptoms (rummaging through her belongings, screaming, making false accusations, anger/agitation) 1-3 days in the last 7 days" and not easily altered. Review of R15's nurse ' s notes revealed that this resident was alert and confused. A Psychiatry follow-up (f/u) dated 7/9/09, stated "Today, resident alert and pleasant. Oriented to person only. Free of expressions of delusions". 9/17/09 Psychiatry f/u stated, "Nursing reports on-going agitation, confusion difficulty with redirection...Met with resident who is alert and very pleasant...Seems to have positive response to present meds (medications- Klonopin, Aricept 10 mg; Ativan 0.5 mg Q 12 hrs. prn (used last 9/14/09)...Seroquel D/C (discontinued) 7/10/09 r/t family's request". 10/15/09 Psychiatry f/u evaluation stated, "Was asked to see due to increased agitation especially in evening. Delusional. Unable to be redirected. Becomes panicked...Today resident alert and pleasant...Spoke with family member #1...agreeable to restarting Seroquel...". 10/15/09 Psychiatry f/u..."Nursing reports on-going confusion and agitation especially in evening hours...Met with resident...Displaying mild to moderate anxiety...Continued dementia related mood and behavioral sx (symptoms). Will increase Seroquel to 25 mg 4 PM & HS (bedtime). Review of R15's clinical record revealed that this resident had 8 unwitnessed falls without injury from 7/15/09 through 11/18/09.	F 221	4. A new resident restraint audit tool (See attached) has been developed and will be completed by nursing administration by 10/15/10 and quarterly thereafter. Results of the audits will be reviewed and discussed at the monthly QA meeting to ensure appropriate restraint usage and reduction.	10/15/10

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F 221	Continued From page 6 On 11/18/09, the physician ordered " Lap buddy for safety" but did not include the medical diagnosis/symptoms that warranted the use of the lap buddy. R15's quarterly MDS assessment dated 11/20/09 indicated changes in her cognitive skills for daily decision making to "moderately impaired-decisions poor; cues supervision required." The facility initiated a care plan dated 11/18/09 entitled "Restraint: Potential for discomfort, injury R/T (related to) use of lap buddy". The care plan goal was "Will be free from discomfort and injury x 90 days. The approaches included "Ensure proper placement of the lap buddy, release q 2 hours for at least 10 min., PT/OT as indicated, Attempt reduction, Explain procedure to family and provide support to resident and her family." In an interview with E2 (Director of Nursing/DON) on 8/27/10 at 12:15 PM, she stated that they discussed use of the lap buddy with the resident's Court appointed guardians (family member #1 and #2) and had obtained verbal permission. On 8/27/10 at 1:00 PM, E9 (Social Service Director) confirmed that there was no signed consent. The facility lack documented evidence that the family members were fully informed and aware of the potential risk (negative outcomes which included "increase in confusion and agitation " and may constitute harm/accident hazard such as strangulation and entrapment associated with restraints), and the benefits and the use of other alternatives. R15 was initially evaluated by PT (Physical Therapy) on 11/6/09 as related to her frequent	F 221		

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F 221	Continued From page 7 falls with a short term goal to "ambulate with RW(roller walker"/ww (wheeled walker) within facility setting only" and a care giver goal to "ambulate independently with AD (assistive device) 3x a week for 30 days" to increase safety. R15 was receiving skilled PT until 12/1/09 when she was placed on Hospice Care per the family's request due to her declining clinical condition. R15 was then placed on a "Functional Maintenance Program" (FMP) on 12/8/09 (approximately 3 weeks after the lap buddy was initiated) to ambulate up to 150 ft with roller walker "assist x 2" and W/C follow 7 x week during the 7-3 PM shift. In an interview with E31 (PT) on 9/15/10 at 11:45 AM revealed that this program was done once a day on the 7-3 PM shift only and the 150 ft ambulation could take 5 minutes for some residents or more minutes depending on the resident's tolerance. Review of R15's FMP record revealed that from 12/8/09 through 01/2010, R15 was on FMP with a 1 staff person assist instead of 2 assist as indicated. The 12/09 FMP record indicated that 16 days out of 24 days, she tolerated 150 ft ambulation, refused 3 x and only ambulated 100 ft 4x. The 01/10 FMP record indicated that R15 tolerated the procedure 95% of the time. The 02/2010 FMP record showed a 95% declined in participation. During an interview with E30 (PTA) and E31(PT) on 9/1/10 at 9:30 AM, they stated that they were aware that R15 was ordered a lap buddy for safety. However, the nursing staff never requested a follow-up to revaluate and/or recommend an alternative for the lap buddy. According to the 11/09 through 3/10 MAR	F 221		

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F 221	Continued From page 8 (Medication Administration Record), the staff signed off placement of lap buddy every shift. However there was lack of documented evidence in the CNAs ADL (activities of daily living) flow sheets , MAR's, TAR's (Treatment Administration Record), and nurse's notes to indicate that R15's lap buddy was consistently released every 2hr for at least 10 minutes as per care plan. Review of R15's clinical record revealed the following sequence of events: 11/18/09 chest X-ray results (due to cough to r/o aspiration) result revealed " Right lower lobe infiltrate". R15 was being treated with Antibiotics for URI (upper respiratory infection). 11/19/09 Psychiatry F/U stated, "...Nursing reports recent falls, increased sedation...met with resident who is asleep and difficult to arouse...". 11/20/09 nurse's note, timed 10:30 AM stated, ... " In w/c (wheelchair) lap buddy in place. Repeating asking ' How do you get this off " referring to lap buddy ' ...alert with confusion...Resident continues with agitation and repeating same sentences given PRN (as needed) Ativan @ 11:00 without significant changes ... ". 11/20/09 nurse's note and timed 1430 stated, "Resident continues with agitation and repeating same sentences, given PRN ativan @ 1100 without significant changes ... " 11/20/09 nurse's note timed 1145 stated, "Resident extremely agitated ...yelling and screaming at this nurse when tried to give Res PRN Ativan po. Lifting up whole w/c to stand up,	F 221		

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F 221	Continued From page 9 yelling at this nurse ...called (Name of MD #1) ...N/O (new order) Ativan 0.5 mg/0.1 ml Gell (sic) Apply top (topical) to wrist x 1 now " . 11/21/09 nurse's note timed 2245 stated, " ...In w/c with lap buddy and chair alarm in place. Resident had increased anxiety this shift. Ativan gel 0.1ml applied at 1700 (5:00 PM) with little effect. Resident kept trying to take lap buddy off of w/c most of shift ... " . 11/22/09 nurse's note timed 2300 stated, "Resident very agitated this shift. Ativan 0.5mg given at 1600 and was not effective. Resident in w/c with lap buddy and alarm in place ...Resident out of w/c for toileting and ambulation with staff assistance. Resident able to make needs known but is very confused. Resident kept trying to remove lap buddy off of w/c and became more agitated when unable to self ambulate. Resident unable to comprehend the use of the w/c and lap buddy...". This same nurse's note also stated that the resident stated "...she was being abused...". 11/23/09 nurse's note timed 2200 stated,"...Resident agitated during the shift and threw 400 (unit) care plan book across the nursing station desk at the CNA because she would not take off the Resident's lap buddy. Ativan given at 1600, and slowly began to take effects after dinner ... " . 11/24/09 nurse's note timed 1530 stated," Addendum ...Resident agitated trying to get out of w/c. Ativan given at 1120." 11/29/09 nurse's note timed 1500 stated, ...did c/o (complaint of) not being able to remove lap buddy, did explain reason for using lap buddy to	F 221		

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F 221	Continued From page 10 no avail; resident continued to try and have staff members remove lap buddy throughout the shift; aide assisted resident prn with continent care; at this time resident in w/c at nsg. (nursing) station for observation " . 11/30/09 nurse's note stated, " Resident OOB (out of bed) w/c with lap buddy. Became anxious around 1300 (1:00 PM) wanting lap buddy taken off. Given PRN Ativan at 1300. CNA walked resident with walker from Nurses station to bathroom for toileting and back again. Resident unstable ambulation. Needs assistance " . 12/2/09 nurse's note indicated...family members #1 and #2 requests change of MD to (Physician #2). 12/6/09 nurse's note timed 0235 stated," Res. OOB (out of bed) in w/c with lap buddy until 1245. Alert with usual confusion ...received PRN Ativan with + (positive) relief ... " 12/6/09 nurse's note timed 2300 stated, " Resident alert with confusion. Very anxious this shift; Ativan given but was not effective. Self propelling w/c with lap buddy in place around facility ... " . 12/7/09 nurse's note timed 0220 stated, " OOB in w/c with lap buddy (from previous shift) very agitated ... " 12/17/09 Psychiatry f/u stated, "Nursing reports agitation continues, combative with care, paranoid. Today resident alert and pleasant. Mobile in wheelchair...will increase Seroquel to 25 mg at noon & 4 PM".	F 221		

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F 221	Continued From page 11 12/28/09 nurse's note timed 0400 stated, "Resident has been OOB and awake into w/c since 2345 (11:45 PM), did try to give Ativan d/t (due to) increased agitation...propelled self around 400 lounge...". 12/29/09 Risperdal 0.5 mg po (by mouth) every 12 hours was prescribed for diagnosis of dementia. 12/31/09 nurse's note stated, "Resident attempting to get out of w/c, sliding her body under the lap buddy. CNA attempted to reposition resident and she became verbally abusive, cursing and very combative, punching, grabbing, kicking and slapping ...Did received Ativan gel with little relief noted". 1/3/10 nurse's note timed 0215 stated, "Resident combative, fighting CNA, kicking and hitting her. Attempting to get out of wc (wheelchair) by sliding self under lap buddy (alarm on). Received PRN Ativan gel at 0120; ...at nurses station sitting quietly napping off and on " . 1/4/10 nurse's note timed 0310 stated, " ...prior to getting in bed resident attempting to slide out of wc (under lap buddy). " 1/7/10 nurse's note timed 0215 stated, "...Resident placed in wc with lap buddy and began to grab things off of nursing station. Resident placed in geri chair with pillow under her head and at this time relaxed, with eyes closed. " 1/22/10 Psychiatry F/U stated, "Nursing reports verbal and physical abuse-staff. Confusion and agitation increases...4PM and continues throughout evening. Today resident alert and	F 221		

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pleasant. Mobile in wheelchair...Change Risperdal to AM and 4 PM-same dose". On 1/29/10 Risperdal order was changed to 0.5 mg. 1 po TID at 0800, 1300 and 1800.

R15, exhibited repeated resistance to the use of the lap buddy while seated in the wheelchair. She attempted to get out of the wheelchair by trying to slide out underneath the lap buddy 3 times (12/31/09, 1/3/10, and 1/4/10).

The daily nurse's notes indicated that R15 had difficulty in adjusting to the presence of the lap buddy on her wheelchair. Her agitation, anxiety, emotional outburst, physical and verbal abusive behaviors continued to increase when she was in the wheelchair with the lap buddy that she could not remove. Instead of engaging in a systematic and gradual process toward reducing the restraint, the facility used PRN Ativan to control her behaviors. The facility failed to recognize that the lap buddy was a stressor to R15 and contributed to her increased agitation, anxiety, depression, emotional outburst, and abusive behavior.

Since 11/06/09, R15 was being treated with antibiotics for right lower lobe (lung) infiltrate/upper respiratory infection.
R15 expired on 03/09/2010 with the immediate cause of death as Dementia-complications of pneumonia, dysphagia and hypertension.

2. During lunch time observations at the "Satellite Dining Room" on 8/18/2010 at approximately 12:00 PM, R5's lap tray was not removed from her wheelchair and the wheelchair did not fit under the table. R5 was left in that same position with the lap tray for approximately 30 minutes and

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F 221	Continued From page 13 she had difficulty accessing/reaching her food from the table. In an interview with E25 (CNA) and E19 (RN) in the dining room on 8/18/2010, they both acknowledged that R5 was supposed to have her lap tray off during meal time. E25 immediately removed R5's lap tray and repositioned her wheelchair when addressed by the surveyor. At that time, R5 commented that her food was already cold. R5's food tray was replaced at 12:45 PM with hot food, however, R5 stated that she lost her interest to eat.	F 221		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined that the facility failed to provide an ongoing program of activities designed to meet the needs of 2 (R11 and R44) out of 34 sampled residents in accordance with the residents' comprehensive assessments, interests, physical, mental and psychological well-being. Findings include: 1. R11 was admitted to the facility on 3/8/05. Review of her quarterly Minimum Data Set (MDS) assessment, dated 6/14/10 revealed that she was	F 248		

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F 248	Continued From page 14 severely impaired for cognitive skills for daily decision making and she had problems with short and long term memory. Review of R11's last quarterly activities assessment, dated 6/14/10, revealed that her current interests included music, watching TV, talking or conversation. R11's activity care plan, updated on 7/1/10, had a stated goal that, "Resident will have attendance at one activity daily x 90 days". Approaches included inviting, encouraging resident to attend (as she looked forward to activities), assisting resident to activities, and providing 1:1 interaction. During a family interview with R11's family member on 8/25/10, the family member stated that R11 enjoyed attending all the activities of the facility and the resident participated fully when cognitively intact. She stated that R11 would benefit from the stimulation of attending more activities. Throughout the survey, R11 was observed in front of the nursing station on her wing from 8:30 AM to 10:30 AM mainly sleeping with little interaction from staff. In the afternoons R11 was observed alone in her room which lacked a TV. R11 was not engaged in any meaningful activity during these times. Review of R11's activity logs from 4/1/10 through 8/17/10 revealed that she attended activities as follows: -In July 2010 she attended activities on 13 out of 22 days. - In June 2010 she attended activities on 7 out of 25 days. - In May 2010 she attended activities on 11 out of	F 248	**F 248** 1 New Activity Care Plans have been written for R44 and R11(see attached) based on discussion with R44 and review of activity interests and abilities for R11. 2 Resident activity interests, abilities and participation will be reviewed for all residents. Activity Care Plans will be revised, as needed. 3 Activities Staff will hold a monthly meeting with residents to determine their desires for new individual and group programs, and to obtain their opinions of existing programs. Notice of the meeting will be posted in advance. 4 Activities staff will meet weekly to review the resident daily activities attendance sheets to determine any change in participation or status, and the need for Activity Care Plan revision.	**10/15/10**

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F 248	Continued From page 15 22 days. - In April 2010 she attended activities on 11 out of 21 days. During an interview with E11 (Activities Assistant) on 8/26/10 at 3:00 PM, she stated that R11 would benefit from more music in her room and she stated that it was R11's passion. She stated that R11 napped in the afternoons and got up late in the mornings. She stated that when activity staff went to get R11 for an activity in the mornings, she was usually not dressed. E11 was surprised that during the survey R11 was observed in front of the nursing station and dressed. E11 stated that they were not documenting refusals or why R11 was not attending and that is something "they need to start doing more of ". On 8/24/10, E12 (Director of Activities) acknowledged these findings. Facility failed to provide an ongoing activity program that met R11's needs as per the care plan to have daily activities. 2. R44 was admitted to the facility on 2/3/05. Review of her quarterly MDS assessment, dated 8/10/10, revealed that she was independent for cognitive skills for daily decision making and she had no memory problems. During an interview with R44 on 8/23/10, she stated that she found most of the activities at the facility boring. She stated that she liked to play games like checkers, but it was hard to find other residents who were capable of playing. She also stated that since her vision was poor, she had a hard time participating in many of the activities.	F 248		

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Review of R44's quarterly activity assessment, dated 8/10/10, revealed that her interests included TV, socializing, music, special entertainment, and sitting outdoors. It also stated that R44's religion was very important to her.

R44's activity care plan, updated on 8/10/10, had a stated goal that "Resident will attend at least 1 out of room activity daily x 90 days."

During an interview with R44's family member on 8/25/10, she stated that R44 used to attend cooking activities and rosary, but she thought that R44 felt less confident to participate since her vision worsened. She stated that R44 loved music, but the sing-a-longs were too juvenile. She stated that she felt that the facility did not have enough activities geared toward residents with low vision, and stated that their activities had become kind of "stagnant."

During an interview with E12 (Director of Activities) on 8/24/10, she stated that some of the higher-functioning residents like to go out to lunch, have discussion groups and enjoyed the entertainment programs. When asked about the activities for visually-impaired residents, she stated that they had large print books, books on tape and large print BINGO cards. She stated that R44 was very independent. She stated that the resident used to play checkers but had not done that for awhile. E13 stated that they keep checkers and other board games behind the counter up front for residents and family to play but they needed to ask staff to get them out if they wanted to use them.

Review of R44's activity logs from 8/2/10 to 8/24/10 revealed that she attended activities on

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F 248	Continued From page 17 nine out of 17 days and they were mostly watching TV or sitting in the lobby. On 8/25/10 at 10:45 AM a piano player was entertaining residents in the facility. R44 was not observed at the activity. When asked why she did not attend, she stated that she did not know that he was performing and was having her hair done. E12 stated that she loved his playing and would change her hair appointment so she can hear the pianist the next time he comes. Also, when asked if she knew that they kept checkers and other games behind the counter up front R44 said no. On 9/2/10 at 11:00 AM, residents were observed in the lobby playing Family Feud. Meanwhile, R44 was observed sitting in her room. This surveyor escorted R44 to the lobby to join the activity at 11:15 AM which was already in progress. Several residents were gathered in front of the TV which was being used for the game. R44 was seated at the far left of the group since there was no room closer to the TV. At 11:30 AM, R44 was observed sitting outside of the dining room. When asked if the game was over, she stated that she left because she couldn't see very well since she could not get close enough to the TV. The facility failed to provide activities that met the interests of R44 and failed to make accomodation for her when there were activities offered that interested her.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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F 279	Continued From page 18 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review it was determined that two (R88 and R100) out of 34 sampled residents failed to have a comprehensive care plan for an identified need. Both residents became incontinent of bladder after admission to the facility and care plans were not developed when this change in status occurred. Findings include: Cross refer to F315, example #2 1. R88 was admitted to the facility on 12/18/09 and was fully continent of bowel and bladder. R88's Bowel and Bladder Assessments were reviewed. The admission assessment, dated 12/18/09, scored R88 at a "2" and the 6/2/10 assessment scored her at a "1". Both indicated that R88 was a good candidate for individualized	F 279	**F 279** 1. Care plans were reviewed and revised accordingly for R88 and R100. (See attached) 2. All resident care plans will be reviewed and revised to ensure accuracy. 3. CNA flow sheets have been revised to reflect the data necessary to coincide with the MDS in order to ensure consistency of data. In servicing of the nursing staff will be been completed by 10/15/10. (See attached) 4. A new resident incontinence audit tool has been developed to ensure care plan revision and will be completed by nursing administration by 10/15/10 and quarterly thereafter. Results of the audits will be reviewed and discussed at the monthly QA meeting to ensure identification of resident change in status and subsequent follow up.	10/15/10

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F 279	Continued From page 19 training. On the next assessment, dated 8/13/10, R88 scored a "12" which indicated that she was a candidate for a toileting schedule (timed voiding). Review of R88's CNA (Certified Nurse Aid) flow sheets from 12/09 through 6/10, revealed that she was fully continent of bladder, however her flow sheets dated 7/10 and 8/10, indicated that she became mostly incontinent. There was no evidence in R88's clinical record that a care plan was developed for her incontinence when her status changed in 7/10. Cross refer F315, Example #3. 2. R100 was admitted to the facility on 4/7/10 and was fully continent of bowel and bladder per the admission MDS (Minimum Data Set) assessment, dated 4/12/10. R100's clinical record lacked evidence of an admission Bowel and Bladder Assessment. The 6/28/10 Quarterly MDS assessment, dated 6/28/10 indicated that the resident had declined to "frequently incontinent" for bladder. On 6/30/10, a Bowel and Bladder Assessment was completed and R100 scored a "5", which indicated that she was a good candidate for individualized training. On the next assessment, dated 7/16/10, R100 scored an "8" which indicated that she was a candidate for a toileting schedule (timed voiding). R100's CNA Flow sheets from 4/10 through 8/10 were reviewed. R100 was fully continent in 4/10, had one episode of incontinence in 5/10, two episodes of incontinence in 6/10, fully continent again in 7/10 and incontinent on at least 20 times	F 279		

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F 279	Continued From page 20 on the 11-7 shift in 8/10. There was no evidence that a care plan for incontinence had ever been developed for R100 when her status changed. Findings were discussed with the administrative staff on 9/3/10 during the informational meeting.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the care plan was reviewed and revised for two (R78 and R88) of 34 sampled residents. R78 had a change in continence status and her care plan	F 280		

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F 280	Continued From page 21 was not updated to reflect the change. R88's ADL (activities of daily living) care plan was not changed when she went from being independent to needing extensive assistance for toileting. Additionally, R88's fall risk care plan was not updated to include new interventions that were added after her last fall. Findings include: Cross refer to F315, example #2 1. a) R88 was admitted to the facility on 12/18/09. Her admission Minimum Data Set (MDS) assessment, dated 12/22/09, indicated that she was independent for walking in her room and toileting. R88's care plan, for ADL function, dated 12/28/09 and last updated on 6/10/10, indicated that she was independent with ambulation and required supervision and set-up with dressing, grooming and hygiene (including toileting). On 7/31/10, R88 fell in the bathroom when toileting herself independently and sustained a fracture to her upper arm. A nurse's note, dated 8/2/10 and timed at 3:15 AM, stated, "...needs assist to and from bathroom..." During an interview with E28 (nurse) on 8/25/10, she stated that R88's care plan for ADL's should have been changed to reflect her increased need for assistance with toileting after her fall. b) Review of R88's clinical record revealed that she fell again on 8/16/10, was sent to the emergency room and returned to the facility with her left arm in a sling. The facility implemented pressure alarms to R88's bed and chair and an alarming seatbelt was place on her wheelchair in response to her recent falls.	F 280	**F 280** 1. Care plans were reviewed and revised accordingly for R78 and R88. (See attached) 2. All resident care plans will be reviewed and revised to ensure accuracy. 3. The CNA data sheets (See attached) containing resident information will be revised to include any resident changes noted by the nursing staff. These sheets will be collected and brought to the SWIFT meeting on a weekly basis for review and revision to the care plans when indicated. 4. A new resident incontinence audit tool (See attached) has been developed to ensure care plan revision and will be completed by nursing administration by 10/15/10 and quarterly thereafter. Results of the audits will be reviewed and discussed at the monthly QA meeting to ensure identification of resident change in status and subsequent follow up.	10/15/10

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F 280	Continued From page 22 R88's care plan entitled, "At risk for injury r/t (related to) falls AEB (as evidenced by) unsteady gait, poor balance.", dated 12/28/09 and last updated on 6/10/10, was reviewed. Their was no evidence that the new interventions of alarms were added to the approaches. Interview with E28 on 8/25/10 confirmed that R88's care plan needed to be updated. The facility failed to review and revise R88's care plans for ADL's and fall risk following her change in status and her recent falls. Cross-refer to F441 example 1 2. Resident R78 had diagnoses that included UTI (urinary tract infection). R78 ambulated independently with a walker and was independent in toileting. Review of R78's clinical record revealed a total of seven (7) urine Culture and Sensitivity laboratory reports with resultant positive organisms Escherichia Coli and Proteus Mirabilis indicating UTI (urinary tract infections). On 5/13/10 the physician was asked to see the resident for redness in the perianal area. Further review of the record revealed no evidence of assessments/evaluations of factors possibly contributing to a history of recurring UTIs and R78's care plan was not revised to identify the UTI problem and interventions for the facility to incorporate pertaining to the UTI.	F 280		

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F 280	Continued From page 23 During an interview with E2 (DON) on 8/25/10- at 3:00 PM, she stated that the UTI could be from poor hygiene, since this "resident wiped herself". Interview with E3 (ADON, Infection Control) on 8/25/10 at 3:45 PM acknowledged that there was no care plan initiated related to R78's UTI problem. The facility developed a care plan for R78 that addressed provision of care for incontinence but did not revise the care plan to address her multiple/recurring symptomatic urinary tract infections.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the comprehensive assessment and plan of care for one (R100) out of thirty-four (34) sampled residents. The facility failed to follow the therapeutic diet orders, written by the physician, when providing a morning snack to R100. Findings include: R100 was admitted to the facility on 4/7/10 with diagnoses which included: Type 2 diabetes, hypercholesteremia (high cholesterol), GERD	F 309		

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F 309	Continued From page 24 (reflux), dementia and anxiety. R100's admission MDS (Minimum Data Set) Assessment, dated 4/12/10 indicated that the resident's cognitive skills for daily decision making were coded as a "1" (modified independence) with some short term memory loss and indicated that R100 had a chewing problem and was on a mechanically altered diet with a dietary supplement between meals. The RAPS (Resident Assessment Protocol Summary) triggered for Nutritional Status and indicated the decision to care plan. Review of the 8/10 POS (Physician Order Sheet) listed R100's diet as "Puree, NCS (No Concentrated Sweets). R100's physician's orders, dated 8/13/10 stated, "Speech: Swallow Evaluation & therapy 1-5 visits. Please (change) diet: ground meats, canned fruit and soft cooked pasta are ok, please puree all vegetables, 0 (no) bread. Continue therapeutic diet recommendations." R100's dietary note, dated 8/18/10 stated, " ...good intake noted @ (at) meals, ...skin intact, diet change noted - Puree, NCS, ground meats, canned fruit and soft cooked pasta are ok, puree all vegetables, No bread per ST (speech therapist) eval/Tx (evaluation/treatment), speech eval noted mod (moderate) oral dysphagia (difficulty in swallowing) char. (characterized) by increased oral transit time/impaired rotary chew, no overt s/s (signs/symptoms) of aspiration per ST, intake noted good @ meals. 50-100% supplements, ..." Review of R100's care plan, dated 4/14/10, entitled "...Altered nutrition R/T (related to) PMH	F 309	**F 309** 1. R100 has had no noted adverse effects since this occurrence. 2. A facility wide resident dietary audit will be completed by the registered dietician by 10/15/10. (see attached) 3. The speech therapist will in-service the nursing, dining services and activity staff on specific diets and the risks. The facility CNAs have been educated to check with their charge nurses prior to providing resident requested snacks. 4. A new resident dining observation audit tool (See attached) has been developed and will be completed by nursing administration by 10/15/10 and quarterly thereafter. Results of the audits will be reviewed and discussed at the monthly QA meeting to ensure accurate delivery of resident meals.	10/15/10

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F 309	Continued From page 25 (past medical history)- DM (diabetes mellitus), hypercholesterolemia, need for therapeutic mechanically altered diet..." revealed that the problem list was revised on 5/19/10 to include "oral dysphagia c (with) (decreased) mastication (chewing)..." and on 8/10 to include "moderate oral dysphagia per ST". The listed approaches were revised on 8/10 and included the updated diet orders of 8/13/10. On 8/27/10 at 11 AM, R100 was observed eating a half toasted bagel with jelly in her room. Review of the CNA (certified nurse assistant) Data Sheet, dated 8/27/10 and timed for the 7-3 shift indicated that R100 was on a "puree" diet. During an interview on 8/30/10 at 11:55 AM, E25 (CNA) stated that she did not know about R100's diet order of "No bread" when she gave R100 a toasted bagel for a snack before lunch on 8/27/10. During an interview on 8/30/10 at 12:16 PM, E2 (Director of Nursing) stated that the CNA should have checked the "CNA Data Sheet" for current diet orders... the resident was listed as "Assist-Puree" on that sheet. E2 stated that if the CNA had followed that sheet, the resident would not have been served a toasted bagel. The facility failed to follow the speech therapist recommendations, the physician's orders, and the plan of care relating to R100's diet.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		

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F 312	Continued From page 26 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and resident care plan review, it was determined that for four residents (R5, R55, R67 and R87) out of 34 sampled, the facility failed to ensure that residents who required assistance were assisted with eating. Findings include: 1. Review of R5's care plan for the problem, "Self-care deficit..." last reviewed on 7/15/10, included the approaches "Set up resident's meal trays... Requires encouragement and reminders to feed self prn (as needed)." Observation of R5 on 8/18/10 during the midday meal revealed the resident seated at a table with four (4) other residents, one of which had a hospice aide assisting her to eat. Although R5's tray had been set up (food cut, drinks opened, etc.) the resident was alternately dozing and periodically picking at her food and there was no staff encouraging or cueing the resident to eat. 2. Review of R55's care plan for the problem, "ADL function/Rehab potential," last reviewed on 6/17/10, included the approach "Feeds self (with) set-up, cueing, supervision and limited assist (varies)." Observation of R55 on 8/23/10 during the midday meal revealed the resident seated at a table with one other resident. Although R55's tray had been set-up, the resident was not actively feeding herself, instead periodically picking at her dessert	F 312	**F 312** 1. R5, R55, R67 and R87 have had no noted adverse effects since this occurrence. 2. All residents were reviewed for their seating arrangements to ensure their assistance and needs with meals are met. 3. A resident seating chart for the satellite dining room has been created and implemented to facilitate monitoring and assistance of all residents. Nursing staff have been assigned specific tables to maintain continuity of care. In-services have been provided to nursing staff. 4. The Unit managers will monitor dining rooms for adherence to this system. The Shift Supervisor Report sheet has been revised to include the monitoring of each dining room. (See attached) This form will be collected and reviewed at the monthly QA meeting to ensure staff compliance.	10/15/10

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F 312	Continued From page 27 (cake). There was no cueing or supervision being provided by staff. 3. Review of R67's care plan for the problem, "Unable to do ADLs..." last reviewed on 8/12/10, included the approach, "Requires total assist Provide assistance and encouragement with meals in satellite dining room." R67 was observed on 8/18/10 during the midday meal seated at a table with four other residents, one of whom had a hospice aide assisting her to eat. Although R67's meal had been set-up, the resident was not eating her meal and was only picking at her roll. There was no staff encouragement, cueing or assistance provided by staff. R67 was again observed on 8/23/10 during the midday meal. The resident was seated at a table with one other resident. Although her meal had been set-up by staff the resident was not eating and there was no staff encouragement, cueing or assistance provided. 4. Review of R87's care plan for the problem, "ADL function/Rehab potential," last reviewed on 6/17/10, included the approach "Feeds self (with) set-up, cueing, supervision and limited assist (varies)." R87 was observed on 8/23/10 during the midday meal. Although the meal was set-up for R87 at approximately 12:00 PM, the resident was not feeding herself. It was not until 12:30 PM that staff began to assist the resident with eating.	F 312		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 28 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility policy and procedures, it was determined that the facility failed to ensure that three (3) residents (R88, R99 and R100) out of 34 sampled, who were incontinent of bladder received appropriate treatment and services to restore as much normal bladder function as possible. The facility failed to re-assess R88's, R99's and R100's bladder continence status when they experienced a decline and failed to follow procedures for the management of the bladder incontinence. All three (3) resident's bladder continence status declined from continent to incontinent. Findings include: The facility's policy entitled "Bowel & Bladder Program" stated, "On admission, readmission, quarterly or in response to change (s) in the resident's condition (sic) will be evaluated for bowel and bladder continence and potential for bowel and bladder retraining in order to prevent urinary tract infection (UTI), and to maintain normal bladder function. Any resident identified as incontinent of urine will be evaluated for causal factors and appropriate actions undertaken to	F 315	1. A bowel and bladder assessment form was completed on R88, R99 and R100 (See attached). The bowel and bladder diaries were also completed for R88, R99 and R100 (See attached). Based on these findings, R88 and R99 were placed on a bowel and bladder program (See attached). These residents were evaluated after 3 weeks and noted to be inappropriate for this individualized program. R100 remains continent with 6 episodes of incontinence noted during the nightshift for the month of September and October (See attached). Upon interview of R100, she has requested that she not be disturbed while she is sleeping. All resident care plans have been updated accordingly. (See attached) 2. A facility wide resident incontinence audit will be completed by nursing administration by 10/15/10. Care plans will be updated accordingly. 3. The bowel and bladder policy (See attached) has been revised and nursing staff will be educated. The program has been modified to include a new Urinary Incontinence Management Evaluation (See attached) as well as a new Elimination Pattern Evaluation (See attached) form. The CNA flow records (See attached) have been revised to reflect the data necessary to coincide with the MDS in order to ensure consistency of data. In servicing of the nursing staff will be completed by 10/15/10.	

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F 315	Continued From page 29 obtain the most effective functioning....The choice of interventions will be dependent on assessment findings including voiding patterns. PROCEDURE: 1. EVALUATE using the Bowel and Bladder Assessment tool on admission, readmission, quarterly, or in response to change in condition. 2. INITIATE Three-Day Continence Management Diary based upon the scoring of the assessment above. Scoring: 0-6 = Good candidate for individualized training; 7-14 = Candidate for toileting schedule (timed voiding); 15-24 = Poor candidate for toileting schedule or retraining...3. Evaluate impact of all medications...4. Determine if further testing is needed such as stress test, post-void residual checks...5. Develop and implement care plan...6. Evaluate response to approaches...7. Re-evaluate effectiveness at least quarterly..." 1. R99 was admitted to the facility on 3/22/10 with diagnoses that included mild dementia, hypertension, metabolic encephalopathy and hypothyroidism. R99's admission Minimum Data Set (MDS) assessment, dated 3/29/10 indicated the resident had short and long term memory problems and her cognitive skills for daily decision making were moderately impaired. The MDS indicated that R99 required one person limited assistance for transfers and one person extensive assistance for toileting and hygiene. The resident was assessed as being continent of urine (scored "0") and as not being on any scheduled toileting plan. The facility's Bowel and Bladder Assessment, completed on 3/22/10 identified R99's score as "8" indicating the resident was a candidate for toileting schedule (timed voiding) per facility	F 315	4. The Unit managers will be responsible for the daily monitoring of this program. The ADON will be responsible for the tracking and trending and will report data at the weekly SWIFT meeting and at the monthly QA meeting.	10/15/10

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F 315	Continued From page 30 policy. The care plan for "ADL (activities of daily living) function rehab potential self care deficit," dated 3/23/10 stated the resident required moderate assistance of one person for hygiene, toileting and transfers and that R99 was continent of B&B (bowel and bladder). A care plan for the problem "Pressure Ulcers at risk for altered skin integrity..." dated 3/24/10 included the approach, "Requires mod (moderate) assist of one with toileting Uses pull-ups for occasional urinary incontinence, provide inc (incontinence) care PRN (as necessary)..." Review of the CNA (certified nurse aide) Flow Sheets from 3/22/10 through 5/11/10 revealed that R99 had eight (8) episodes of urinary incontinence documented. Nurse's notes from 3/22/10 through 5/8/10 stated the resident was continent of urine and was assisted to the bathroom by CNAs. A nurse's note, dated 5/9/10 and timed 3:30 PM, stated the resident was alert with some confusion and at times incontinent at hour of sleep. A nurse's note, dated 5/10/10 and timed 10 PM, stated the resident was able to make her needs known, transferred independently, ambulated with a rolling walker and was continent of bowel and bladder with occasional incontinence. On 5/13/10 at 6:50 AM, the nurse's note stated that R99 was "assist (with) toileting by CNA. Noted to be incontinent of urine..." A nurse's note, dated 5/14/10 and timed 3:30 PM, stated that the CNA reported that the resident was having more incontinence of urine and that it would be passed onto the next shift to check the urine for bacteria (possible infection). On 5/15/10 at 9:45 PM, the	F 315		

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nurse's note stated that a urine dipstick (test strip used to check for infection) was completed and was within normal limits.

Review of the CNA Flow Sheets from 5/12/10 through 8/23/10, revealed that R99 was now incontinent of urine daily. Nurse's notes during this same time period indicated that the resident was at times toileting independently and at other times required assistance with incontinence care.

There was no evidence in the clinical record that the facility re-assessed R99 at the time of her increased incontinence (mid May) or that a voiding diary was completed in order to determine voiding patterns in an attempt to improve and/or maintain continence.

A quarterly Bowel and Bladder Assessment, completed on 6/12/10, listed a score of "7" which indicated R99 was a "candidate for toileting schedule (timed voiding)." There was no evidence that a voiding diary was completed at this time.

A quarterly MDS assessment, dated 6/14/10 indicated that R99 was dependent for transfers and totally dependent for toilet use. The MDS also indicated the resident was incontinent of urine (scored "4" - "had inadequate control Bladder, multiple daily episodes") and was not on any scheduled toileting plan.

The care plan for "ADL function" was revised on 6/24/10 and listed the problem, "Incont of bladder, requires extensive assistance (with) incont care. The approaches were revised to indicate that R99 now required extensive assistance of one person with toileting. There was no evidence that a voiding diary was completed at this time or that

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F 315	Continued From page 32 any new interventions were implemented in an attempt to improve R99's continence status. On 8/23/10 at 9 AM an interview was conducted with R99, who was mildly confused. R99 was asked if she had any difficulty using the bathroom and if she needed help. R99 stated that she had no problems. When asked if she had any problem with incontinence she stated that sometimes when she gets up from bed she has to go "fast" and at times "doesn't get there in time." During an interview with E21 (CNA) on 8/23/10 at 4:05 PM, she stated that she has worked with R99 since the end of May and that the resident was both continent/incontinent. E21 stated that the resident toileted herself independently and would call for assistance if she needed help with incontinence care. E21 stated that she knew the resident was incontinent because she throws her briefs in the bathroom trash can. On 8/24/10 at 11:30 AM, E20 (CNA) was interviewed and stated that the resident used to be continent of urine and that she recalled when R99 became incontinent. E20 also stated that the resident was still incontinent, but she would take/remind her to use the bathroom throughout her shift. E20 stated the resident was forgetful and needed reminders. E20 also stated that she had never completed a voiding diary for the resident. In an interview with E18 (nurse) on 8/24/10 at 2:25 PM, E18 stated that the resident "has always been incontinent." E18 acknowledged that a voiding diary was never completed and subsequently no planned toileting scheduled. E18 stated that R99's day shift aide always took her to	F 315		

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F 315	Continued From page 33 the bathroom, however, she agreed that this aide was not on duty around the clock. On 9/3/10 at 9:45 AM, during an interview with E19 (nurse) this surveyor was provided with copies of attendance records for a bowel and bladder inservice conducted on 4/1/10. The "self learning inservice" consisted of staff reading the facility policy and signing off that they read it. E19 acknowledged that when a resident became incontinent after being continent this would constitute a change in status and warrant implementation of an assessment, a voiding diary and a subsequent scheduled toileting plan. E19 stated that the nursing Unit Manager/Supervisor should initiate a voiding diary or inform the floor/medication nurse of the need for one. The floor/medication nurse should monitor that the CNAs are completing the diary. Although the facility had policies and procedures pertaining to a bladder program, the facility failed to ensure that systems were in place for the staff to identify a decline in bladder continence and then activate the appropriate interventions. The facility failed to ensure that R99 received appropriate treatment and services to restore as much normal bladder function as possible. R99, who became increasingly incontinent after having been assessed as continent of bladder upon admission, was not provided with these services. R99 experienced a decline in her continence status which resulted in harm to the resident. 2. R88 was admitted to the facility on 12/18/09 with multiple diagnoses including osteoporosis, hypertension, major depression and difficulty walking.	F 315		

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F 315	Continued From page 34 R88's quarterly MDS assessment, dated 5/31/10, indicated that her cognitive skills for daily decision making were independent and she had no memory problems. Additionally, R88 was fully continent of bowel and bladder and was independent for toileting. The facility's Bowel and Bladder Assessment, completed on 6/2/10, identified R88's score as "1" which indicated that she was a good candidate for individualized training. Review of the CNA Flow Sheets from admission in 12/09 through 6/10 revealed that R88 was fully continent of bladder. A nurse's note, dated 6/22/10 and timed 7 AM, stated, "...noted to be incontinent of urine this AM...", however, according to the CNA flow sheet, she was fully continent of bladder on 6/22/10. A nurse's note, dated 7/14/10 and timed 8:15 AM, stated, "....requests help at times with ADL's but mostly independent, mixed incontinence of B&B..." Another nurse's note, dated 7/21/10 and timed 7 AM, stated "...May or may not toilet self. Assistance offered (every 2 hours) to toilet. Resident may be incontinent but uses toilet as well..." Review of R88's CNA Flow Sheet for 7/10, revealed that she was mostly incontinent on the 11 PM to 7 AM shift and about half of the time on the 3 to 11 PM shift. Review of a nurse's note, dated 7/31/10 and timed 5:30 AM, revealed that R88 was found lying in the doorway of her bathroom. She had been ambulating with a rolling walker. R88 complained	F 315		

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of left shoulder pain, was sent to the hospital and was found to have sustained a fracture to her left upper arm.

Review of R88's CNA Flow Sheet for 8/10, revealed that she was not only incontinent of bladder on the 11 PM to 7 AM shift, but also on the 7 AM to 3 PM shift and all but 8 times on the 3 PM to 11 PM shift.

A Bowel and Bladder Assessment was completed on 8/13/10 for R88 that identified a score of "12" indicating that she was a candidate for a toileting schedule (timed voiding) per facility policy.

No evidence was found in R88's clinical record that the facility initiated a three-day voiding diary.

During an interview with E24 (CNA) on 8/31/10, she stated that she took R88 to the bathroom every two hours but the resident was usually already wet. She stated that R88 used to ask for help to go, but she had not been asking lately.

A significant change MDS for R88 was completed on 8/23/10 (during the survey) which indicated that the resident was totally incontinent of bladder and dependent on staff for toileting.

The facility failed to re-access R88's bladder continence in 7/10 when she first showed a decline. As a result, R88's continence status continued to decline until she became almost totally incontinent of bladder. The facility did not implement a voiding diary until 8/27/10 after it was brought to the facility's attention by the surveyor.

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F 315	Continued From page 36 3. R100 was admitted to the facility on 4/7/10 with diagnoses that included type 2 diabetes, dementia, depression, anxiety, osteoarthritis, GERD (reflux), and DVT (deep vein thrombosis). R100's admission MDS (Minimum Data Set) Assessment, dated 4/12/10 indicated that the resident's cognitive skills for daily decision making were coded as a "1" (modified independence) with some short term memory loss. The assessment indicated that R100 was fully continent of bowel and bladder. She was not on a scheduled toileting plan but, was totally dependent for toileting and required one (1) person physical assistance. R100's care plan for "ADL function/rehab potential...", dated 4/9/10 included the approach "...Provide extensive assist of one c (with) ....grooming, hygiene, toileting..." Review of R100's clinical record lacked evidence that the Bowel and Bladder Assessment was completed on admission. However, there was a Three-day Continence Management Diary, dated 4/7/10 through 4/9/10 with no documentation for 4/8/10 and missing documentation on 4/9/10 for the 7-3 and 11-7 shifts. Available documentation indicated that R100 was found to be clean and dry or she was assisted to the toilet with positive results. CNA Flow sheets were reviewed and revealed that R100 was fully continent of bladder in 4/10. R100 was documented as both incontinent and continent on the 11-7 shift on 5/21/10, otherwise she was fully continent during 5/10. Review of the 6/10 CNA flow sheets revealed that R100 remained continent of bladder except for the 11-7	F 315		

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F 315	Continued From page 37 shifts on 6/27/10 and 6/28/10. A nurse's note, dated 4/8/10 and timed 6:55 AM stated, "... Res. (resident) assisted to BR (bathroom) X (times) 2. gait slow/unsteady..." A nurse's note, dated 4/9/10 and timed 11 PM stated, "... got OOB (out of bed) to the bathroom only, Continent of B&B (bowel and bladder)..." On 4/11/10, a nurse's note timed for 9 PM revealed that R100 was "...Continent of B&B..." and on 5/2/10 at 2:20 PM, a nurse documented "... Requires assistance c (with) walker & staff to bathroom..." R100's Quarterly MDS, dated 6/28/10 indicated that R100's cognitive skills for daily decision making were "severely impaired" with short term memory loss. Additionally, R100 remained totally dependent for toileting and was coded as "occasionally incontinent" of bladder. The facility's Bowel and Bladder Assessment, completed on 6/30/10, identified R100's score as "5" which indicated that she was a "good candidate for individualized training." Although review of the CNA flow sheets from 7/1/10 through 8/6/10 revealed that R100 was continent, a Bowel and Bladder Assessment completed on 7/16/10, listed a score of "8", which indicated that R100 was a candidate for toileting schedule (timed voiding). There was no evidence that a Three-day Continence Management Diary was done as per facility policy. Review of the 8/10 CNA flow sheets revealed that R100 was incontinent of bladder on the 11-7 shifts for 20 out of 31 nights. There was no 11-7 shift documentation on 8/28, 8/30 and 8/31/10.	F 315		

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F 315	Continued From page 38	F 315		

Otherwise, R100 was documented as being fully continent on the day and evening shifts for 8/10.

There was no evidence found in R100's clinical record that another "Bladder and Bladder Assessment" was done after 7/16/10. The only voiding diary found was the incomplete diary of 4/17/10.

While the care plan for "ADL function/rehab potential...", dated 4/9/10 approach for "...extensive assist of one c .... toileting..." was revised (undated) to "total" assist, the careplan was not updated to include incontinence.

During an interview on 8/30/10, E25 (CNA) stated that R100 was not on a toileting schedule because the resident was able to tell staff when she needed to go to the bathroom. E25 stated that R100 was continent during the day.

During an interview on 8/31/10, E26 (CNA) stated that the resident was walked to the bathroom. E26 stated that R100 sometimes gets agitated when asked if she needs to be toileted and does not always want to get up. E26 stated that frequently R100 was found to be incontinent at the beginning of the shift or a shortly afterwards.

During an interview on 8/31/10, R100 stated that she used the call bell to alert staff when she needed to be toileted. R100 was asked what happens if staff do not come right away when she used the call bell. She stated, "I would try to hold it and hope I don't wet myself." When asked if that ever happened, she stated, "Yes."

During an interview on 8/31/10, E27 (charge nurse) was unable to explain why R100 had a

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F 315	Continued From page 39 decline in continence. E27 denied ever seeing the facility's Bowel and Bladder Assessment despite it being in the resident's chart. He denied that a Three-day Continence Management Diary was completed for R100. He stated that he was not involved in R100's bowel and bladder assessment nor was he familiar with the facility's policy. After being shown the policy, E27 acknowledged that the facility policy was not followed. Findings were discussed during an interview on 8/31/10 with E2 (Director of Nursing). E2 acknowledged that the facility failed to follow their policy after assessing a change (decline) in bladder status in 6/10 when a Quarterly MDS assessment was done, they failed to follow-up on the 7/16/10 bladder assessment and failed to implement their policy (assess and follow-up with a Three-day Continence Management Diary) in 8/10 when CNA flow sheets revealed that R100 was incontinent numerous times on the 11-7 shift. Although the facility was documenting data on the CNA Flow Sheets, it was unclear as to what system was in place to analyze and act upon this data when indicated.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

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F 323	Continued From page 40 Based on record review, observation and interview, it was determined that the facility failed to provide an environment that was free of accident hazards as was possible for two (2) residents (R11 & R44) out of 34 sampled. The facility failed to ensure that a Hoyer lift did not present an accident hazard for R11. The CNA failed to ensure that the metal hook of the hoyer lift handle was secured when attempting to place the Hoyer lift's leg under the bed. The handle with the metal hook swung and hit the back of R11's head causing a laceration that required the insertion of 2 staples in the hospital emergency room. The facility failed to ensure that R44's side rail was secure. Both siderails were observed to be loose and moved back and forth when grasped posing an accident hazard. In addition, the facility failed to maintain an environment free from accident hazards as evidenced by an unlocked linen chute accessible to residents on the first floor of the facility. Findings include: 1. The facility's policy entitled "Mechanical Lifts" was reviewed. R11 had diagnoses that included complex fracture of left humerus inoperable, dementia, osteoporosis and cerebral vascular accident. Review of the Minimum Data Set (MDS) assessment dated 6/18/10 revealed that R11's cognitive skills for daily decision-making were severely impaired and she was totally dependent on staff for activities of daily living (ADLs). The facility established a care plan dated 5/10/10 entitled "Potential for pain, altered skin, decline in ROM (range of motion) R/T (related to) (L) distal femur fx (fracture)" and with the last review date of 6/10/10. The interventions included "Hoyer lift	F 323	**F 323** **# 1** 1. Since the incident, R11 has had no change in her condition. 2. A mechanical lift competency (See attached) was completed by the Staff Educator for all CNAs. This competency includes a step by step demonstration by the CNA in the presence of the Staff Educator. Threshold compliance for this competency is 100%. 3. The mechanical lift policy (See attached) was reviewed and revised and staff in serviced accordingly. All facility CNAs signed off on the policy revision (See attached) as well as on the disciplinary action to follow if non-compliant with this policy. 4. Annual competencies will be completed at the Mandatory Review Day and during New Staff Orientation. The Staff Educator will forward to the monthly QA meeting, the number of competencies completed. The report will include the pass/fail rate and the subsequent education provided to nursing staff.	**10/15/10**

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F 323	Continued From page 41 and 2 assist with all transfers". A nurse's note dated 7/4/10 (0715) stated, "At 0515 Aide alerted this nurse of resident acquiring a head injury which did result in two lacerations on the posterior side (head), aide (1 CNA) was performing hoyer setup when one of the hoyer arms (handles) hit the resident in the head, used abd (abdominal) pads to apply pressure to lacerations to halt bleeding, while acquiring vs (vital signs)...observed that resident's pox/pulse ox (oxygen saturation with the patient's blood monitored with a pulse oximeter device) was 85% (normal range 92 -100%), placed resident on O2 (oxygen) via nasal canula which before she left facility increased to 92%, bleeding was stopped before EMT's transferred resident to ER...for evaluation...neuro checks is performed prior to leaving facility". A nurse's note dated 7/4/10 (1020) stated, "Resident returned from ED (Emergency Department) at 1010 via stretcher with 2 EMTs (Emergency Medical Technicians). Resident had 2 staples applied to laceration on back of head...". Review of the facility's investigation included a written statement from E29 (CNA) dated 7/4/10 which stated, " This morning at around 5:15 AM I was giving care and preparing resident (R11) to get up. Unfortunately, one of the dangling hoyer hooks hit her on the head. This happened accidentally as I was trying to lower the hoyer handles to hook them to the lifting hoyer pads on the bed...". In an interview with E29 on 8/24/10 at approximately 3:10 PM, he confirmed that he was alone in the room. He further stated that R11's head was contracted and was always up and she could not lay flat, so the metal hooks of the	F 323	**# 2** 1. Resident 44 was not harmed by this practice. The side rails for R 44 were replaced on 8/23/10 2. All bed rails have been checked for proper operation 3. All staff, including Nursing, Maintenance and Housekeeping will be educated on the proper use of the bed rails. The staff will also be educated on the proper use of the work order System to report any deficiencies relating to bed rails or other safety issues 4. The proper operation of bed rails will be a section in the Bed Operation Preventative Maintenance Program to be checked on a monthly basis. (See attached). Maintenance Director will monitor compliance.	**10/15/10**

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F 323	Continued From page 42 dangling hoyer handle hit her on the back of her head. E29, on preparing R11's transfer to a chair with a Hoyer lift failed to call for assistance to ensure R11's safety. E29 failed to secure the hoyer lift handle to prevent it from dangling. R11 sustained a 1 inch laceration to posterior aspect of her head when it was hit by the dangling hoyer lift handle bar and was sent out to the hospital for evaluation and sutures (2 staples). The facility's policy and procedure indicated that 2 staff members must be present when preparing, positioning the sling pads underneath the resident and attaching the S-hooks of the chains to the swivel bar hooks prior to lifting and performing transfers using a mechanical lift. In an interview with E19 (RN,Staff Developer) on 8/24/10, she stated that E30 (PTA) inserviced all staff on 6/9/10 on the use of the Hoyer lift. In an interview with E30 (PTA) on 8/30/10 at 1:00 PM confirmed that the Hoyer lift taken into the resident's room must be away from the bed. One person should prepare the pad underneath the resident and the 2nd person hooks the pad to the handles of the Hoyer lift. Since there was no opportunity to observe R11 for transfer with a Hoyer lift, 2 observations of Hoyer lift transfers on 8/26/10 and 8/30/10 on R44 (another resident with a Hoyer lift transfer) was done correctly with 2 persons and according to facility policy . Review of facility's incident report and result of investigation revealed that E2 and E19 acknowledged on 7/9/10 that E29 "operated	F 323	**#3** 1. No resident was identified or harmed by this practice 2. The lock assembly on the laundry Chute door was repaired on 8/31/10 3. All staff, including Nursing, Maintenance and Housekeeping will be educated on the proper operations of the Laundry Chute door and the use of the Work order system in case repair is necessary 4. Maintenance will check the Laundry Chute door operation at least two (2) times daily on the AM / PM tours. This door assembly will also be included on the Preventative Maintenance program on a monthly basis (See attached forms). Maintenance Director will monitor compliance.	

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F 323	Continued From page 43 hoyer lift without a second person resulting in Resident injury. Per policy, transferring residents via hoyer lift requires two staff members at all times". E29 was "careless" and "violated safety rules". Consequently, the unsecured/dangling Hoyer lift handle bars and hook became an accident hazard to R11. 2. R44 was observed on 8/23/10 at 9:45 AM sitting up in bed with both side rails in the up position. She stated that she used them to help her turn herself in bed. Both side rails were observed to be loose and moved back and forth when grasped posing an accident hazard. During observations on 8/23/10 at 3:00 PM, with E15 (maintenance director), he agreed that R44's side rails were too loose. At 3:30 PM, E15 stated that he replaced the side rails. Observations at that time confirmed that the side rails fit properly. The facility failed to maintain an environment free of accident hazards as evidenced by loose side rails on R44's bed. 3. Observations on 8/18/10 through 8/25/10 of the first floor linen chute door revealed that the linen chute was unlocked and accessible to residents. The chute had a locking system that was in disrepair. Staff interviews with E13 (Maintenance) and E14 (Maintenance) confirmed this finding. The door to the chute was observed locked on 8/27/10 at 1:30 PM and 8/30/10 at 10:00 AM after it was repaired.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

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F 325	Continued From page 44 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility policy, it was determined that the facility failed to maintain acceptable parameters of body weight for one resident (R22) out of thirty-four (34) sampled residents. The facility failed to monitor meal consumption patterns, failed to monitor weights and failed to consistently weigh R22. Additionally, they failed to immediately implement dietary interventions in a timely manner to address her significant weight loss. Findings include: The facility's policy entitled, "Weight Policy" was reviewed. R22 was admitted to the facility in 2004. A History and Physical, dated 4/30/10, revealed diagnoses including dementia, debility, failure to thrive, and depression. Review of a quarterly MDS (minimum data set) assessment, dated 12/29/09, listed R22's cognitive skills for daily decision-making as	F 325	1. R22 had no change in her condition as a result of this practice. This resident continues to be weighed on a weekly basis (See attached) and reviewed at the SWIFT meeting. 2. A facility wide weight audit (See attached) was completed to ensure that all resident weights and supplements are accurately implemented. This audit will be completed by the Registered Dietician. 3. The weight policy (See attached) has been reviewed and revised and staff will be in- serviced by 10/15/10. The monthly weight tool (See attached) has also been revised to include dates and times of weights. A new Dietician Recommendation sheet (See attached) has also been implemented. This new form will be initiated by the Registered Dietician, the physician will document on the recommendation form and the unit managers will ensure the order was obtained and transcribed correctly. The unit managers will audit nursing compliance in regards to weights utilizing the Daily/Weekly Weight Tool (See attached). 4. The Registered Dietician will audit the recommendation forms and report percentages of follow through at the weekly SWIFT meeting and at the monthly QA meeting.	10/15/10

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F 325	Continued From page 45 severely impaired with short and long term memory problems; she required one person extensive assistance with eating. An Initial Nutritional History/Assessment Data Collection Form, completed by E38 (Registered Dietitian) on 1/7/10, listed R22's usual body weight (UBW) as 97-105 lbs. R22 was tolerating a mechanical soft, NAS (no added salt) diet and received one can of Ensure Plus (supplement) daily. Review of R22's "Monthly Weight and Vital Sign" Sheet and monthly MAR's (Medication Administration Records) revealed that her weights (wts.) were: 8/09 - 103.0 lbs. 9/09 - 100.8 10/09 - 100.3 11/09 - 102.4 12/09 - 105.1 1/10 - 106.8 2/10 - 100. Reweigh 100.2 (6.2% wt. loss in 1 month) 3/10 - 100.3 (no weekly wts. done) 4/6/10 - 90.2 (10.1 lb./10% wt loss in 1 month). Subsequent weekly weights for 4/10 were: 93.6, 90.2, 91.9 (actual dates were not indicated) 5/10 - 91.7 (5/11), 87.1 (5/18), 89.3 (5/25). No wt. done on 5/4/10. 6/10 - 88.8 (6/1), 83.8 (6/8), 88.3 (6/15), 91.6 (6/22), 87.0 (6/29) 7/10 89.0 (7/6), 95.0 (7/20). No wts done on 7/13 or 7/27. 8/10 - 87.7 (8/19) E38's Nutrition note, dated 3/3/10 stated, "... (3/10) wt pending...Rec. (recommend) weekly wts..." The 3/10 MAR stated, "Weekly weights	F 325		

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F 325	Continued From page 46 Thursdays start April 1st 2010" - No weekly wts were done in 3/10. Additionally, E38 suggested an increase of R22's Ensure pudding to twice a day, however, review of R22's physician's orders revealed that the increase in the supplement was not ordered until 3/30/10. R22's 3/10 and 4/10 MAR's revealed that the Ensure pudding order was changed from daily at 10 AM to twice a day at 10 AM and 2 PM on 3/30/10, however the documentation indicated that the resident only received the 10 AM supplement on 3/30/10 and 3/31/10. The increase to twice a day was not implemented until 4/1/10. On 4/1/10, a Quarterly Nutrition Review was completed using previous weights. On 4/15/10, E38 identified a 10.1 lb wt loss (10% wt loss in 1 month). She "...spoke to daughter concerning wt, dentures are being replaced, daughter feeding resident lunch - not interested in (decreasing) diet, wants to continue mech soft, NAS, continues on weekly wts, ensure pudding, Rec add Two Cal HN (supplement) one can daily, intake noted 25-100%." E38's nutrition note, dated 5/27/10 stated, "... wt fairly stable since last mo (month)..." R22 continued on weekly wts, supplements adjusted to receive Ensure pudding at 10 AM and 2 Cal HN at 2 PM and R22's dentures were replaced. E38's nutrition note, dated 6/9/10, recommended that Beneprotein 1 scoop twice a day and a multivitamin with minerals be added to the current supplements (Ensure pudding & 2 Cal HN). E38 also suggested that an Albumin level be obtained (measures protein levels and are an indication of	F 325		

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F 325	Continued From page 47 nutritional status). E38 documented that R22 had a 7.9 lb wt loss in one month (8.6%), had "a decline per MD" and that R22's oral intake at meals was 10-100%. Review of R38's meal consumption records revealed that her intake was poor (0% - 50%) for 16 of 93 meals in 3/10, 31 of 90 meals in 4/10 and 27 of 93 meals in 5/10. There was no evidence that this decrease in consumption was identified. On 6/16/10, a Quarterly Nutrition Review stated that on 6/12/10, R22 was sent to the ER because she swallowed her partial plate (denture). E38 recommended that the Ensure pudding be increased to twice a day and R22 had a speech evaluation done and was noted to have oropharyngeal dysphagia (difficulty swallowing). E38's nutrition note, dated 6/30/10 stated, "...Labs - 6/18/10 - Albumin 3.7 - WNL (within Normal Limits)..." R22's diet was changed to Pureed. E38's nutrition note, dated 7/21/10 stated, "...wt stable this qtr (quarter)... tol (tolerating) diet c (with) supplements/supercereal/beneprotein, on MVIT (multivitamin), continues on weekly wts, Labs 7/15/10 -Alb (Albumin) 3.6 (WNL)...intake 25-100%..." Review of R22's 7/10 MAR revealed that only two of four weights were done. During an interview on 8/30/10 at 8:20 AM, E38 confirmed that weekly weights were not done in 3/10. E38 stated that she repeatedly asked for R22's weights to be done at the weekly SWIFT (Skin, Weight loss, Infections, Falls, Therapies) meetings. She stated that because weekly weights were not done, she could not adequately monitor R22's condition. E38 stated that she saw	F 325		

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F 325	Continued From page 48 R22 weekly and although she did not always have R22's current weights, she had interventions in place. During an interview with E2 (Director of Nursing) on 8/30/10 at 9:30 AM, she confirmed that weekly weights were not obtained as recommended. E2 stated it was the responsibility of the nurse managers to follow through and if a weight was not done on a specific date, it should be obtained the next day. E2 confirmed that E38 could not properly monitor R22 without weights. The facility failed to adequately monitor weekly weights as per E38's recommendation for R22 who had a 10.1 lb weight loss (10%) in one month (3/10 to 4/10). Weekly weights were also not obtained on 5/4/10, 7/13/10 and 7/27/10. Additionally, the facility failed to implement the dietitian's recommendation to increase the Ensure pudding supplement for almost a month (recommended on 3/3/10 and ordered on 3/30/10) and then failed to provide the additional supplements for 2 days after it was ordered. It was also unclear from the documentation how the facility staff analyzed and evaluated the resident's meal intake and what system the facility had in place to incorporate the RD's recommendations into the physician's orders.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329		

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F 329	Continued From page 49 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and interviews, it was determined that the facility failed to ensure that four (R48, R85, R88, and R105) out of 34 sampled residents' drug regimens were free from unnecessary drugs. R85 received Xanax since admission for insomnia without any clinical indication for use. The facility also failed to ensure that AIMS (Abnormal Involuntary Movement Scale) monitoring was completed for R48, R88 and R105, who received antipsychotics, to detect signs of potential adverse consequences. Additionally, the facility failed to discontinue the use of Klonipin, an antianxiety medication, following recommendation by the psychiatric consultant. Findings include: 1. R88 was admitted to the facility on 12/18/09 with diagnoses including major depression.	F 329	1. R48 and R105 have had their Abnormal Involuntary Movement Scales completed (See attached). R85 and R88 are not currently receiving medications that require the Abnormal Involuntary Movement Scale be completed. 2. A facility wide resident audit was completed by nursing administration to ensure that all residents requiring Abnormal Involuntary Movement Scale were updated. 3. The Psychoactive policy has also been reviewed and revised to include changes and modifications (See attached).The unit managers will be responsible for the quarterly completion of the Abnormal Involuntary Movement Scale form in coordination with the care planning process. The Psychoactive Reduction form has been revised to include the date of the most recent Abnormal Involuntary Movement Scale completed (See attached). A new Psychoactive Medication Consent form (See attached) has been initiated for all new psychoactive medications ordered. Any pharmacy consultant recommendations regarding psychoactive medications will be faxed to the consultant psychiatrist for review and follow through. In servicing for the nursing staff will be completed by 10/15/10.	

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F 329	Continued From page 50 a) Review of R88's clinical record revealed a psychiatric consult note, dated 4/1/10, that recommended Klonipin for anxiety. The medication was ordered on 4/1/10 and R88 continued to receive it through 8/16/10. On 7/31/10, R88 fell and was hospitalized for a fracture to her left upper arm. Review of the hospital discharge orders, dated 8/1/10, revealed a recommendation that stated, "Psychiatric evaluation - ? adjust meds ? fall secondary to overmedication." Physician's orders, dated 8/2/10, stated "Please re: consult psychiatry to help adjust antidepressants. I am concerned pt's (patient's) fall is b/c (because) of oversedation." A psychiatric consult note, dated 8/5/10, stated "...In light of current need for percocet (for pain), will d/c (discontinue) Klonipin." Review of R88's clinical record lacked evidence that the Klonipin was discontinued. Review of the resident's Medication Administration Record (MAR) for 8/10, revealed that she continued to receive Klonipin until 8/16/10 when she fell again and was sent to the emergency room. b) Review of R88's clinical record revealed that she received Seroquel, (antipsychotic medication), for her diagnosis of depression, from 3/4/10 through 8/16/10. The clinical record lacked evidence that an AIMS (Abnormal Involuntary Movement Scale-aids in the early detection of tardive dyskinesia, a movement disorder, as well as providing a method for on-going surveillance) had been completed at the	F 329	4. The ADON will be responsible for reviewing the Abnormal Involuntary Movement Scale forms for completion and will report findings at the monthly QA meeting. The Pharmacy consultant will also report findings at the meeting.	10/15/10

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F 329	Continued From page 51 onset of treatment with Seroquel or anytime thereafter while the resident was receiving the medication. 2. Review of R48's medication regimen revealed the resident was receiving Seroquel, which had been ordered on 7/29/10. The clinical record lacked evidence that an AIMS had been completed at the onset of treatment with the Seroquel. 3. Review of R105's medication regimen revealed the resident was started on Abilify (antipsychotic) on 8/6/10. The clinical record lacked evidence that an AIMS had been completed at the onset of treatment with Abilify to serve as a baseline for on-going monitoring. During an interview with E2 (Director of Nursing) on 8/25/10 at 1:15 PM, she stated that the AIMS was to be completed initially at the start of an antipsychotic and periodically thereafter. 4. R85 was admitted to the facility on 5/9/09 with diagnoses including multiple sclerosis and insomnia. A Quarterly MDS (Minimum Data Set), dated 6/14/10 indicated that R85's cognitive skills for daily decision making were independent without short or long term memory problems. R85's Admission orders, dated 5/5/09, included	F 329		

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F 329	Continued From page 52 Xanax (antianxiety medication) 0.25mg by mouth every evening at bedtime for insomnia. Review of R85's clinical record revealed that she continued on the same dose of Xanax through 8/10. During an interview on 8/31/10 at 11:40 AM, R85 denied ever having anxiety or insomnia. She stated that she did not know she was taking Xanax for insomnia and stated she did not recall the facility informing her of the risk/benefits for this medication. R85's 6/10, 7/10 and 8/10 MAR's (Medication Administration Records) revealed that Xanax was given daily as ordered. Review of the "Behavior/Intervention Monthly Flow Record" during this time period indicated that R85 exhibited no symptoms of insomnia. Review of R85's nurses notes, dated 12/27/09 and timed 3 PM through 9/2/10 and timed 2:15 PM, lacked documentation of complaints of anxiety or insomnia. R85's Psychotropic Reduction Meeting sheets, dated 7/28/09, 11/10/09, 3/9/10 and 6/28/10 were reviewed. Xanax was included in the meds reviewed on each date, however, there were no recommendations to reduce the medication. Review of the "Consultant Pharmacist Record of MRR (Medication Regimen Review)", dated 7/20/10 stated, "Xanax gdr (gradual dose reduction)?" During an interview on 8/31/10 at 11:50 AM, E36 (nurse) reviewed the record and stated that R85 was admitted with Xanax on 5/5/09 and remained on it. E36 stated she was unaware of any complaints of anxiety or insomnia.	F 329		

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F 329	Continued From page 53 Review of a Physician's Progress Note, dated 2/8/10 stated, "...10. Insomnia - pt (patient has Xanax.... states she doesn't need meds to sleep. T/C (To consider) D/C'ing (discontinuing)..." A Physician Progress Note, dated 4/30/10 stated, "...6. Insomnia - no problems sleeping at night per nursing. Pt gets Xanax every night..." During an interview on 8/31/10 at 12:40 PM, E37 (Psychiatric nurse) stated that she had never been asked to see R85, but worked with the psychiatrist who saw R85. E37 reviewed the Psychotropic Reduction Meeting sheets as previously listed, Physician Progress Notes (2/8/10 & 4/30/10), Physician Order Sheets, and the Pharmacy Consultant recommendation of 7/20/10. E37 stated that R85 would be a good candidate to try a gradual dose reduction. A Consult report was completed by E37 on 9/2/10, regarding "Med eval R/T (related to) Xanax." The report stated that nursing reported "no mood or behaviors... Satisfactory sleep,...alert & pleasant...able to make needs known.... Denies mood sx (symptoms). Denies sleep problems... Recommendation Trial of Xanax taper & then change to prn (as needed) if tolerated." The facility failed to discontinue or gradually reduce the dose of R85's Xanax when there was no indication of insomnia. Findings were discussed with Administrative staff during the informational meeting on 9/3/10.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		

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F 333	Continued From page 54 This REQUIREMENT is not met as evidenced by: Based on record review, review of other documentation as indicated and interview, it was determined that the facility failed to be free of significant medication errors for one resident (R100) out of thirty-four (34) sampled residents. Findings include: a. Review of R100's clinical record revealed a physician's order, dated 7/15/10, which stated, "Consult vascular... re (regarding) DVT (Deep Vein Thrombosis)..." On 7/16/10, R100 returned to the facility after insertion of an IVC (Inferior Vena Cava) Filter (surgically implanted device to prevent fatal pulmonary emboli). Prior to the hospitalization, record review revealed that the facility's physician discontinued R100's Coumadin on 7/13/10 per family request. The hospital discharge medication orders, dated 7/16/10, indicated that the resident was to stop taking "Coumadin 2 mg Oral daily." Review of the facility's "Physician Admission/Monthly Orders", dated 7/16/10 included an order to take "Coumadin 2 mg po daily @ 1600 (4 PM) Diagnosis: DVT". The doctor's communication book revealed documentation, dated 7/23/10 that stated, "...Pharmacist consultant would like Coumadin and ASA orders clarified. 325 mg ASA too high? Family was questioning use of Coumadin? ..." A physician order, dated 7/23/10 stated, "D/C Coumadin..." Review of the 7/10 MAR post hospitalization revealed that R100 received daily doses of Coumadin from 7/16/10 through 7/22/10 (total 7 doses) before it was discontinued on 7/23/10. During an interview on 9/1/10 at 10:25 AM, E18	F 333	**F 333** 1. There were no adverse effects to R100 from this practice. Physician order was followed. The resident is currently receiving Aspirin therapy. 2. A facility wide chart audit was completed to ensure medication orders and delivery was accurate. 3. The 24 hour chart check continues on the 11-7 shift. The Shift Supervisor Report (See attached) has been revised to now include oversight and compliance with chart checks. 4. Each supervisor and unit manager will be responsible for reporting compliance with medication transcription and delivery at the monthly QA meeting.	**10/15/10**

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F 333	Continued From page 55 (nurse) stated that she incorrectly transcribed the hospital interagency discharge orders to the facility admission order sheet. She added that she does not normally work on that wing, was unfamiliar with the resident's history, and was very busy that day. b. R100 had a physician order, dated 6/24/10, which stated, "Lotemax (corticosteroid) Opth (ophthalmic) Sol (Solution) 1 gtt (drop) BID (twice a day) OU (to both eyes) X (times) 10 days." The medication was given as ordered and discontinued on 7/4/10. The 7/16/10 hospital discharge medication order for "Lotemax one drop to both eyes two times a day" was transcribed onto the facility's "Physician Admission/Monthly Orders", dated 7/16/10. Review of the "Consultant Pharmacist: Drug Regimen Review", dated 7/22/10, stated "... Lotemax 10 days - tx (treatment) comp (completed) 7/4...". The doctor's communication book revealed documentation, dated 7/23/10 that stated, "...were (sic) Lotamax only suppose (sic) to be 10 days?" R100's Physician order, dated 7/23/10 stated, "... D/C Lotemax." R100's 7/10 MAR (post hospitalization) revealed that R100 incorrectly received Lotemax from 7/16/10 through 7/23/10 when it was discontinued. During an interview on 9/1/10 at 10:25 AM, E18 (nurse) stated that she did not compare the physician's orders post hospitalization against the prehospitalization orders to make sure that R100 was continuing with the same plan of care.	F 333		
F 364 SS=B	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364		

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F 364	Continued From page 56 value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to serve food that was palatable and at acceptable temperatures. Findings include: During Stage 1 of the survey, residents (who preferred not to be identified) complained of food served too cold. Two resident trays were pulled to test at breakfast time on 8/24/10 at 7:25 AM. Food temperatures were as follows: Tray #1: Strata: 112 degrees Fahrenheit (F); milk: 57 degrees F. Surveyors tasted the food and determined that the hot food was cool and the cold food was warm. Overall, the food was not palatable due to the temperatures. Findings were acknowledged by E15 (Director of Dining Services) that they had problems with their food delivery system in regards to maintaining proper serving temperatures.	F 364	**F 364** 1. No resident was identified as being affected by this practice. 2. Tray delivery system has changed. All trays are delivered in an enclosed cart to the floors/wings for distribution to maintain proper temperatures. 3. Nursing staff now signs off on delivery log once the cart has been delivered to the wing/floor. Dietary and nursing staffs were both in serviced on this systematic change. (See attached policy) 4. Test tray evaluations are conducted according to Performance Improvement Program schedule specified by Morrison Senior Dining Corporate policy and signed off by Director of Dining Services. (See attached). Chef is to sign off if Director is absent.	9/25/10 9/25/10
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		

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F 371	Continued From page 57 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the dietary department and staff interviews, it was determined that the facility failed to prepare, serve, distribute and store food under sanitary conditions. Findings include: 1. Observations in the kitchen on 8/18/10 at 9:45 AM revealed two boxes of non-pasteurized shell eggs stored inside the walk-in refrigerator. Interview with E16 (Dietary staff) revealed that they offered the unpasteurized shelled eggs to residents "any way they want if that's what they prefer", including fried and over-easy eggs. 2. Observation of the kitchen steam table on 8/20/10 at 11:25 AM revealed that the vegetable (string beans) was held at 133 degrees Fahrenheit (F). Interview with E17 (Cook) revealed that she was unaware that the temperature of the string beans were supposed to be at or above 140 degrees F. Staff interview with E15 (Director of Dining Services) requested the beans be reheated to the proper temperature. 3. Observation of a kitchen prep cart during the tour of the kitchen on 8/18/10 at 9:40 AM revealed milk (in glasses) at a temperature of 52 degrees F. During an interview with E16 (Dietary staff) he stated that the milk was being set-up for next day's breakfast and that the milk should be	F 371	**F 371** **# 1** 1. No resident was identified as being affected by this practice. 2. Non-pasteurized eggs were immediately discarded. 3. Pasteurized cage free eggs were scheduled for, and delivered on 8/20/10. Documentation was provided to state surveyors immediately during the survey process. 4. Pasteurized cage free eggs are the only available option for purchase on the corporate managed order guide between Morrison and Sysco to ensure no other egg product enters the facility for production. All Dietary supervisors will check Sysco deliveries and monitor products received for compliance.	**8/21/10**

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F 371	Continued From page 58 kept at 35 to 40 degrees F. E15 confirmed they should not serve the milk to residents. 4. Observation of a bucket storing wiping clothes on 8/18/10 at 10:15 AM inside the kitchen dairy sink revealed that it lacked sanitizing solution. Interview with E15 confirmed this finding. 5. On 8/18/10, the food-contact surface area of twelve (12) out of twelve (12) blue plastic divided resident plates stored on the clean and ready to use rack were observed stained and wet. 6. The food-contact surface area of three (3) of seven (7) blue plastic resident cereal bowls stored on the clean and ready to use rack were observed scratched and not easily cleanable. E17 confirmed this finding on 8/24/10 at 7:25 AM. 7. On 8/18/10 at 9:50 AM, the food contact surface of one (1) out of two (2) frying pans and the non-food contact surface area of two (2) out of the same two frying pans stored on the clean rack above the meat sink were observed with yellow/brown grease deposits. On 8/20/10 at 11:25 AM, the nonfood contact area of a small frying pan was observed with grease deposits on it. The nonfood contact area of two (2) out of six (6) food pans stored on the clean rack were observed with encrusted food debris and yellow grease deposits. 8. Observations of the stainless steel dairy sink and a smaller food sink surfaces on 8/18/10 revealed the sinks with yellow stains. 9. Observations of the co-ed dietary staff bathroom near the kitchen on 8/18/10 at 11:05 AM, revealed an uncovered trash container. A	F 371	**#2** 1. No resident was identified as being affected by this practice. 2. Vegetables were removed from steam well, immediately re-heated in steamer, and returned to steam well for meal service at proper temperature 3. All vegetables will be placed in the steam well in a perforated pan so that the heat from the wells can reach the product and maintain proper temperature throughout meal service period. Staff was in-serviced on this procedure. 4. Temperature logs are kept and signed off by kitchen supervisors to ensure temperatures are maintained at proper standards per policy as stated on Temperature logs. (see attached) All Dietary supervisors are monitoring temperature logs for compliance. **# 3** 1.No resident was identified as being affected by this practice 2. Milk identified as above proper temperature was discarded immediately.	**10/2/10**

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILTON & HATTIE KUTZ HOME	704 RIVER ROAD WILMINGTON, DE 19809

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 58 kept at 35 to 40 degrees F. E15 confirmed they should not serve the milk to residents. 4. Observation of a bucket storing wiping clothes on 8/18/10 at 10:15 AM inside the kitchen dairy sink revealed that it lacked sanitizing solution. Interview with E15 confirmed this finding. 5. On 8/18/10, the food-contact surface area of twelve (12) out of twelve (12) blue plastic divided resident plates stored on the clean and ready to use rack were observed stained and wet. 6. The food-contact surface area of three (3) of seven (7) blue plastic resident cereal bowls stored on the clean and ready to use rack were observed scratched and not easily cleanable. E17 confirmed this finding on 8/24/10 at 7:25 AM. 7. On 8/18/10 at 9:50 AM, the food contact surface of one (1) out of two (2) frying pans and the non-food contact surface area of two (2) out of the same two frying pans stored on the clean rack above the meat sink were observed with yellow/brown grease deposits. On 8/20/10 at 11:25 AM, the nonfood contact area of a small frying pan was observed with grease deposits on it. The nonfood contact area of two (2) out of six (6) food pans stored on the clean rack were observed with encrusted food debris and yellow grease deposits. 8. Observations of the stainless steel dairy sink and a smaller food sink surfaces on 8/18/10 revealed the sinks with yellow stains. 9. Observations of the co-ed dietary staff bathroom near the kitchen on 8/18/10 at 11:05 AM, revealed an uncovered trash container. A	F 371	3. Milk is now poured and temperatures checked immediately prior to distribution to residents for that specific meal. Dietary staff was in- serviced on proper procedure 4. Milk is listed along with all other food products on Temperature logs. All Dietary supervisors monitor for compliance. **#'s 4,5,6,7&8** 1. No resident was identified as being affected by this practice. 2. Contents of bucket in question regarding sanitizer solution was immediately discarded. All divided plates identified as stained have been removed from circulation. Cereal bowls that were identified as scratched have been discarded and others are being gradually phased out from service and replaced. Kitchen sinks were immediately de- limed and stains were removed.	**10/2/10**

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ADDITIONAL SHEET

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ADDITIONAL SHEET

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F 371	Continued From page 59 covered receptacle for female sanitary products was not available. Staff interview with E15 confirmed this finding.	F 371	**F 441** #1 1. Care Plan for R78 was reviewed and revised to now include a history of urinary tract infections. (See attached) Education was provided to the resident by nursing administration on proper pericare hygiene. However, resident was unable to recall after only 10 minutes. (See attached) 2. The monthly infection tracking log which includes all residents with orders for antibiotics as well as identified infections was reviewed by the Infection Control Coordinator. All self-toileting residents with urinary tract infections diagnosed within the last 2 quarters will receive education on pericare technique by the nursing staff. 3. The monthly infection tracking log will be revised to include residents with a urinary tract infection that self-toilet (See attached). If a resident is self-toileting and develops a urinary tract infection, the infection control coordinator will be responsible for identifying resident education needs. Nursing staff will be assigned to complete the education and the documentation on the Resident Education Form (See attached).	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		

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F 441	Continued From page 60 infection. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that the information in the Infection Control surveillance records maintained by the facility were used to determine if any corrective actions were warranted for one (1) resident (R78) out of 34 sampled. Additionally, the facility failed to store and process linens to prevent the spread of infection. Findings include: 1. Resident R78 had diagnoses that included Alzheimer's, hearing loss and UTI (urinary tract infection). According to R78's annual Minimum Data Set (MDS) assessment dated 6/14/10, her cognitive skills for daily decision-making were "moderately impaired-decisions poor; cues supervision required". R78 had short term and long term memory problems, was able to make herself understood. R78 ambulated independently with a walker, was independent in toileting, however, needed limited assistance of one staff person for personal hygiene and extensive assistance with bathing. Review of R78's clinical record revealed the following urine Culture and Sensitivity laboratory reports results with positive organisms meaning she had UTI's: 3/9/10 - >100,000 cc-gram negatives rod 3/11/10 - >100,000cc-Escherichia Coli 4/1/10 - >100,000 cc-Gram negatives rod 4/5/10>100,000cc Escherichia Coli	F 441	4. The Education forms will become part of the infection control reports and will be reviewed at the QA meeting on a monthly basis for tracking and trending. **# 2** 1. No resident was identified as being affected by this practice 2. The Exhaust system in the soiled linen receiving was repaired and is in operation as of 9/29/10 3. Maintenance and Laundry staff have been educated on the proper operations of the exhaust system 4. The Exhaust system operation will be implemented in the Preventative Maintenance Program on a monthly basis and checked twice (2) daily on the maintenance AM/PM checks (See attached). Maintenance Director will monitor compliance.	**10/15/10** 10/15/10

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F 441	Continued From page 61 4/12/10>100,000cc Proteus Mirabilis 5/12/10->1000,000cc gram negative rods 5/14/10 - >100,000cc Proteus Mirabilis A physician's progress note dated 5/13/10 (10:20) stated, "asked to see patient for redness in perianal area-Urine w/ + for UTI-Bactrim DS". Further review of the record revealed no evidence of assessments/evaluations of factors possibly contributing to R78's history of recurring UTI's and no care plan was initiated for this resident identifying the UTI problem and to address interventions to prevent recurring UTI infections. During an interview with E2 (DON) on 8/25/10- at 3:00 PM, she stated that the UTI's could be from poor hygiene, since this "resident wiped herself". Interview with E3 (ADON, Infection Control) on 8/25/10 at 3:45 PM acknowledged that there was no care plan initiated related to R78's UTI problem. Interview with E33 (LPN) on 9/1/10 at 11:10 AM revealed that she had not observed the resident using the toilet and wiping herself. She further stated that she was not aware if the resident was educated on how to wipe herself in a manner to prevent urinary tract infections. In an interview with E32 (CNA) on 9/1/10 revealed that she had told R78 to wipe front to back and had observed her do it. However, E32 was not sure if this resident was consistently following what she told her. E32 further stated that she did not report this to the other shifts. 2. Observations of the soiled linen receiving area of the laundry room on 8/24/10 at 10:00 AM revealed the room was not well ventilated and	F 441	#3 1. No resident was identified as being affected by this practice 2. A new 42 cu.ft impermeable container has been purchased and is in place to collect the linens sent down the laundry chute to prevent the bags from lying on the floor 3. Laundry and maintenance staff have been educated on the proper use of this container 4. Laundry staff checks the container 4 times per shift. This process is included on the daily AM/PM check list (See attached). Maintenance Director will monitor compliance.	10/8/10 9/30/10

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F 441	Continued From page 62 was not maintained under negative pressure. There was no ceiling exhaust vent to the outside in the room. An interview with E14 (Maintenance Director) confirmed this finding. 3. On 8/24/10 at 10:00 AM, one bag of soiled linen was observed on the floor of the receiving area of the laundry coming from the linen chute on the first floor of the facility. Interview with E14 and E8 (Laundry staff) revealed that bags always fell from the chute onto the floor of the receiving area.	F 441		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined that the facility failed to provide a sanitary environment as evidenced from stained/dirty rugs throughout the hallway of the facility, and storage of trash carts and soiled linens on hallways of the facility. Findings include: 1. Observations of the facility hallway rugs on 8/18/10 though 9/3/10 revealed the rugs to be stained or dirty. Facility staff was observed steaming the rugs on 8/19/10 in front of the dining room and the stains or dirt did not come off. 2. Observations of the facility hallways on 8/18/10 and 8/19/10 revealed trash and soiled linen carts stored on the hallways and some of the contents	F 465	**F 465** **# 1** 1. No resident was identified as being affected by this practice 2. Carpet has been cleaned by facility staff, but will also be professionally cleaned by an outside contractor – Service Master. (Carpet replacement is in process- not part of POC) 3. The contractor will provide cleaning in-services to the Floor Care and Maintenance staff 4. Floor Care staff will maintain the carpets based upon professional guidance. Carpets are checked twice (2) daily for spills and soil by Housekeeping / Floor care staff (See attached AM/PM checklist). Maintenance Director will monitor compliance.	**10/15/10**

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F 465	Continued From page 63 were overflowing. On 8/30/10 on the hallway of the 300 wing, the trash cart had an urine odor. Interview with E13 confirmed this finding.	F 465	**F 465** **#2**	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to maintain clinical records that were complete and accurately documented for one (R22) out of thirty-four (34) sampled residents. R22, who lost a significant amount of weight from 3/10 to 4/10, was receiving nutritional supplements. The facility failed to consistently document the percentage of the nutritional supplements consumed. Findings include: Cross refer to F325. R22's 3/10 MAR (Medication Administration Record) listed Ensure pudding (supplement) to be given daily at 10 AM. On 3/30/10, the Ensure pudding was increased to be given twice a day at 10 AM and 2 PM. The 3/10 MAR lacked	F 514	1 &2.No resident was identified as being affected by this practice 3. A total of 4 new alcoves will be constructed on the 200 and 400 wings to store nursing equipment and linen to eliminate hallway clutter and prevent cross contamination. Nursing staff will be in-serviced on the specific use of these alcoves and of the need to empty soiled linen and trash carts throughout the day 4. Compliance will be monitored during daily rounds and monthly Safety and Environmental rounds.	**10/15/10**

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F 514	Continued From page 64 documentation of the percentage of the amount of Ensure pudding consumed on 23 of 31 days. Review of the 4/10 MAR lacked documentation of the percentage of the amount of Ensure pudding consumed on 4/13/10 through 4/16/10 (4 days). On 4/16/10, the Ensure pudding order was decreased to be given at 10 AM and 2 CAL HN (supplement) 4 oz by mouth at 2 PM was added. The 4/10 MAR lacked documentation of the percentage of the Ensure pudding consumed for 5 of 14 additional days and the 2 Cal HN was missing the same documentation for 7 of 14 days. During an interview on 8/30/10 at 8:20 AM, E38 (Registered Dietitian) acknowledged that the lack of documentation of the percentage amount of supplements consumed can make it difficult to adequately monitor a resident's intake. During an interview on 8/30/10 at 9:30 AM, E2 (Director of Nursing) stated that it was the facility's policy to document the percentage amount of supplements consumed on the MAR's but, acknowledged that it was not always done. The facility failed to consistently document the percentage of the nutritional supplements consumed by R22.	F 514	**F 514** 1. R 22 had no change in her condition as a result of the event. The resident is currently receiving supplements as ordered. The resident's medication administration record now includes the current supplement order and percentage consumed (See attached). 2. A facility wide audit will be completed to ensure that all resident weights and supplements are accurately completed.(See attached)This audit will be completed by the Registered Dietician. 3. A new Dietician Recommendation sheet has also been implemented (See attached). This new form will be initiated by the Registered Dietician, the physician will document on the recommendation form and the unit managers will ensure the order was obtained and transcribed correctly.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520	4. The Registered Dietician will audit the Recommendation forms and report percentages of follow through at the weekly SWIFT meeting and at the monthly QA meeting.	10/15/10

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F 520	Continued From page 65 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain a quality assurance program that developed and implemented appropriate plans of action to correct quality deficiencies. The facility identified a problem with incontinence of bladder function assessments and documentation but failed to implement an ongoing monitoring program to correct the problem. This resulted in the facility to have deficient practices in assessing bladder continence status. Findings include: Cross refer F 315 Review of the facility's "Quality Assurance/Quality Improvement Policy" revealed that "Each department is responsible to complete and gather data in a particular time frame by way of checklists or monitors that have been established". The QAA had a "Monthly Meeting	F 520	**F 520** 1. A bowel and bladder assessment form and bladder diaries were completed for R88, R99 and R100. All resident care plans have been updated accordingly. (see attached) 2. A Nursing Comprehensive Resident audit, Restraint audit, and Incontinence audit will be completed by Nursing Administration and a Dietary audit will be completed by the Registered Dietician for all residents by 10/15/10. Care Plans will be updated accordingly 3. The CNA data sheets (See attached) containing resident information will be revised to include any resident changes noted by the nursing staff. These sheets will be collected and brought to the SWIFT meeting on a weekly basis for review and revision to the care plans when indicated. 4. Results of all audits will be reviewed and discussed at the monthly QA meeting to ensure identification of resident change in status and subsequent follow up.	10/15/10

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F 520	Continued From page 66 Procedure" to review and identify trends that may have an impact on resident care and services; develop a plan of action to be shared with facility staff. The QAA had "Sub-Committees" to further investigate and/or develop specific recommendations when issues were identified as a "result of ongoing monitoring, investigative procedures, concerns, incidents and/or surveys by regulatory bodies". The following staff were interviewed on 9/3/10 at 8:25 AM: E7 (CNA) stated that if there were changes with continency, that is, from continent to signs of incontinency, she reported the changes to the charge nurse. E18 (LPN) stated, she "will assess resident's changes in bladder function, call the physician and document assessment then report to the Unit Supervisor". During an interview with E28 (LPN-Unit Supervisor) on 9/3/10 at 9:30 AM, she stated that she conducted audits to make sure that all the assessments were done quarterly from the chart. She would not know if they were not in the chart. The changes were discussed in the "Daily Stand Up" meetings if they had something to work with, like the Bowel and Bladder changes and they would talk with the physician to check for incidents of UTI's. E28 stated that the QAA committee only talked about Falls, UTI's, Skin tissues (wounds) and incident reports. Bladder function changes was not discussed in QAA meeting. Three (3) residents (R88, R99 and R100) out of 34 sampled, who were incontinent of bladder failed to receive appropriate treatment and	F 520		

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F 520	Continued From page 67 services to restore as much normal bladder function as possible. The facility failed to re-assess R88's, R99's and R100's bladder continence status when they experienced a decline and failed to follow procedures for the management of the bladder incontinence. All three (3) residents' bladder continence status declined from continent to incontinent. The QAA committee failed to develop and implement appropriate plans of actions to correct identified bladder function changes. Consequently, the facility failed to maintain a quality assurance program that developed and implemented appropriate plans of action to correct quality deficiencies. The facility identified a problem with incontinence of bladder function assessments and documentation but failed to implement an ongoing monitoring program to correct the problem.	F 520		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085043	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 9/3/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 166	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents

This REQUIREMENT is not met as evidenced by:
Surveyor: 21976
Based on interviews and facility policy, it was determined that the facility failed to investigate, document, and follow up on a grievance for one resident (R82) regarding missing items. Findings include:

On 8/18/10, in an interview with R82, the resident reported missing a pair of white pants. R82 stated she had reported this to facility staff who searched for the missing item but was unable to find it

On 8/25/10 at 7:55 AM (a week later), R82 stated that the laundry staff searched for the white pants and was told that staff was unable to recover the missing item. She stated that the staff told her the pants were discarded. R82 stated she was not told whether the item would be replaced

On 8/24/10 at 11:30 AM, during interviews with E6 (Nurse) and E7 (CNA) they stated that they were aware the resident had lost a pair of white pants. Interviews with E8 (Laundry staff) and E9 (Social Service Director) revealed that they were unaware of R82's missing pants. On 8/25/10 at 12:30 PM, E9 stated that she was in charge of the missing item process and confirmed that the facility lacked a procedure for handling missing items.

Review of facility procedures lacked evidence of a procedure for missing items Logs or reports of the incidents of missing items could not be found

Review of R82's clothing inventory list lacked quantities of her clothing items Interview with E10 (Admission Nurse) on 8/23/10 revealed that when a resident was admitted to the facility, the quantity of each clothing item should be recorded. E10 provided R82's inventory form to the surveyor which was blank

The facility failed to have policies and procedures for addressing residents ' missing items

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STATE SURVEY REPORT

NAME OF FACILITY: The Milton & Hattie Kutz Home

DATE SURVEY COMPLETED: September 3, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201	**Skilled and Intermediate Care Nursing Facilities** **The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced annual and complaint survey was conducted at this facility from August 18, 2010 through September 3, 2010. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 86. The survey sample totaled 94 residents, which included 40 census residents, 20 admission residents and 34 stage 2 residents.	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code**	**3201.1.2** Cross- refer to F 156, F 221, F 248, F 279, F 280, F 309, F 312, F 315, F 323, F 325, F 329, F 333, F 364, F 441 #1 and #3, F 465 and F 520 **Completion date 10/15/10**

rovider's Signature _____ Title EXECUTIVE D.R. Date 10/8/10

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	requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 9/3/10, F156, F166, F221, F248 F279, F280, F309, F312, F315, F323, F325, F329, F333, F364, F441 examples #1, & 3, F465, and F520.		
3201.7.5	**Kitchen and Food Storage Areas**		
3201.7.5.1	**Facilities shall comply with the Delaware Food Code.** Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 3-304.14, 3-401.11, 3-501.16, 4-101.11, 4-601.11, and 5-501.17 of the State of Delaware Food Code. Findings include: **3-304.14 Wiping Cloths, Use Limitation.** **(A) Cloths that are in use for wiping food spills shall be used for no other purpose.** **(B) Cloths used for wiping food spills shall be:** **(1) Dry and used for wiping food spills from tableware and carry-out containers; or** **(2) Wet and cleaned as specified**	**3201.7.5.1** Cross-refer to F 371	**Completion date 10/6/10**

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	under ¶ 4-802.11(D), stored in a chemical sanitizer at a concentration specified in § 4-501.114, and used for wiping spills from food-contact and nonfood-contact surfaces of equipment. **(C) Dry or wet cloths that are used with raw animal foods shall be kept separate from cloths used for other purposes, and wet cloths used with raw animal foods shall be kept in a separate sanitizing solution.** Cross refer to CMS 2567-L, survey date completed 9/3/10, F371, example #4. **3-401.11 Raw Animal Foods.*** **(A) Except as specified under ¶ (B) and in ¶¶ (C) and (D) of this section, raw animal foods such as eggs, fish, meat, poultry, and foods containing these raw animal foods, shall be cooked to heat all parts of the food to a temperature and for a time that complies with one of the following methods based on the food that is being cooked:** **(1) 63°C (145°F) or above for 15 seconds for:** **(a) Raw shell eggs that are broken and prepared in response to a consumer's order and for immediate service,** ***(D) A raw animal food such as raw egg, raw fish, raw-marinated fish, raw molluscan shellfish, or steak tartare; or a partially cooked food***	

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	such as lightly cooked fish, soft cooked eggs, or rare meat other than whole-muscle, intact beef steaks as specified in **¶ (C) of this section, may be served or offered for sale in a ready-to-eat form if:** ***(1) The food establishment serves a population that is not a highly susceptible population,*** Cross-refer to CMS 2567-L survey date completed 9/3/10, F371 example #1. **3-501.16 Potentially Hazardous Food, hot and cold Holding.*** ***Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under § 3-501.19,*** **potentially hazardous food shall be maintained:** **(B) At 5°C (41°F) or less, except as specified under ¶ (C) of this section and §§ 3-501.17, 3-501.18, and 4-204.111.** Cross refer to CMS 2567-L survey date completed 9/3/10, F371 example #2 and #3. **4-101.11 Characteristics.*** **Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart**	

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	colors, odors, or tastes to food and under normal use conditions shall be: **(D) Finished to have a smooth, easily cleanable surface;** Cross refer to CMS 2567-L survey date completed 9/3/10, F371 example #6. **4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.*** **(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch.** **(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.** **(C) Non-food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 9/3/10, F371 example #5, 7, 8. **5-501.17 Toilet Room Receptacle, Covered.** **A toilet room used by females shall**	

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	be provided with a covered receptacle for sanitary napkins Cross refer to CMS 2567-L survey date completed 9/3/10, F371 example #9.	
3201.7.6	**Sanitation and Laundry**	
3201.7.6.3.1	**For on-site laundry processing, the facility shall:** **Provide a room under negative air pressure for receiving, sorting, and washing soiled linen.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 9/3/10, F441 examples #2	**3201.7.6.3.1** Cross-refer to 441 # 2 **Completion date 10/8/10**
3201. 9.0	**Records and Reports**	
3201. 9.1	**There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:**	
3201. 9.1.7	**Medication administration record (MAR) including medications, dosages, frequency, route of administration, and initials of the nurse administering each dose. The record shall include the signature of each nurse whose initials appear on the MAR.**	**3201.9.1.7** Cross-refer to F 514 **Completion date 10/15/10**

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	This requirement is not met as evidenced by: Cross refer to CMS 2567-L survey date completed 9/3/10, F514.	
3201. 9.1.8	**Inventory of resident's personal effects upon admission.** Review of R82's and R105's clothing inventory list lacked quantities of their clothing items. Interviews with E10 (Admission Nurse) on 8/23/10 revealed that when a resident is admitted to the facility, the quantity of each clothing item should be recorded. The form was blank for R82 and R105.	**3201.9.1.8** 1.Inventory lists have been completed for R 82 and R 105 2. Availability of inventory lists for all residents will be assessed and completed if not present on the medical chart 3.Staff will be in serviced on a new missing item policy and procedures for the completion of resident inventory lists 4. Audit of the completion of Inventory lists is a part of the Comprehensive Audit (See attached) and will be monitored by the unit manager **Completion date 10/15/10**